STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING _____ B. WING _____	R-C 02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL POND HEALTH CAMPUS	**1014 MILL POND LN GREENCASTLE, IN 46135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint #IN00162418 completed on 1/13/15.

This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on 1/13/15.

This visit was in conjunction with the Investigation of Complaint #IN00167793

Survey Dates: February 26 & 27, 2015

Facility number: 004550
Provider number: 155736
AIM number: 200526450

Survey Team:
Mary Weyls, RN TC

Census bed type:
SNF: 17
SNF/NF: 37
Residential: 31
Total: 85

Census payor type:
Medicare: 17
Medicaid: 23
Other: 45
Total: 85

Mill Pond Health Campus was found to be in compliance with 42 CFR part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint #IN00162418.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155736	A. BUILDING _____ B. WING _____	R-C 02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL POND HEALTH CAMPUS	**1014 MILL POND LN GREENCASTLE, IN 46135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed 3/6/15 by Brenda Marshall, RN.	{F 000}		